CalPERS

GROUP CONTINUATION COVERAGE

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT "COBRA"

PERS-HBD-85 (Rev 08/11)

PERS USE ONLY - DOCUMENT REFERENCE NUMBER

Public Employees' Retirement System
Office of Employer and Member Health Services
P.O. Box 942714
Sacramento, CA 94229-2714
888 CalPERS (or 888-225-7377)
TTY: For Speech & Hearing Impaired - (916) 795-3240 FAX (916) 795 -1313

INSTRUCTIONS FOR COMPLETING THIS FORM ARE ON THE REVERSE SIDE. *PLEASE TYPE*

PART A: ORIGINAL QUALIFYING EVENT AND DATES

1. Type of Action	2. QUALIFYING EVENT	3. EVENT DATE	4. COBRA ENROLLMENT PERIOD
☐ NEW ☐ CHANGE	☐ EMPLOYMENT SEPARATION/TIMEBASE REDUCTION ☐ DIVORCE/LEGAL SEPARATION ☐ CHILD CEASES TO BE A DEPENDENT ☐ DEATH OF AN EMPLOYEE/RETIREE ☐ DEPENDENT CONTINUATION - ORIGINAL ENROLLEE ELIGIBLE FOR MEDICARE		FROM ____ 01 ____ TO ____

PART B: ENROLLEE INFORMATION

5. COBRA ENROLLEE (MAY BE DIFFERENT THAN SUBSCRIBER)	6. SUBSCRIBER (EMPLOYEE/RETIREE)
SOCIAL SECURITY NUMBER ___ — ___ — ____	SOCIAL SECURITY NUMBER ___ — ___ — ____
NAME	NAME
ADDRESS	
CITY, STATE, ZIP	
DAY PHONE ( ) — MARRIED ☐ YES ☐ NO	
BIRTHDATE — SEX ☐ MALE ☐ FEMALE	

PART C: CARRIER INFORMATION

7. NAME AND ADDRESS OF HEALTH PLAN

PLAN CODE: _____ PREMIUM: $_____

PHONE:

PART D: DEPENDENT INFORMATION

ACTION CODE	LIST OF ALL PERSONS (including self) TO BE ENROLLED: (FIRST) (MI) (LAST)	DATE OF BIRTH MO. DAY YR	FAMILY RELATIONSHIP
	SSN		
	(FIRST) (MI) (LAST)		
	SSN		
	(FIRST) (MI) (LAST)		
	SSN		
	(FIRST) (MI) (LAST)		
	SSN		

SELF

PART E: ENROLLMENT CHANGES

9. NAME OF PRIOR HEALTH PLAN	11. PERMITTING EVENT CODE	12. PERMITTING EVENT DATE	13. EFFECTIVE DATE OF CHANGE
10. PRIOR PLAN CODE			01

PART F: SIGNATURE OF ENROLLEE

14. I AGREE TO PAY THE PREMIUM FOR THE COVERAGE DIRECTLY TO THE CARRIER LISTED ABOVE. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO MAKE FUTURE PAYMENTS IN A TIMELY MANNER AS REQUIRED BY THE CARRIER. I UNDERSTAND THAT FAILURE TO PAY THE PREMIUM WILL RESULT IN AUTOMATIC TERMINATION OF COVERAGE. I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY.

SIGNATURE OF COBRA ENROLLEE (SEE ATTACHMENT FOR PRIVACY INFORMATION) — DATE SIGNED

PART G: AGENCY INFORMATION

15. AGENCY NAME _____

AGENCY CODE _____ UNIT CODE _____

16. HEALTH BENEFITS OFFICER'S SIGNATURE

DATE RECEIVED_____ PHONE_____

PRIVACY INFORMATION

Submission of the requested information is mandatory. The information requested is collected pursuant to the Government Code Sections (20000. et. seq.) and will be used for administration of the Board's duties under the California Public Employees' Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Portions of this information may be transferred to another government agency (such as your employer) but only in strict accordance with current statutes regarding confidentiality. Failure to supply the information may result in the System being unable to perform its functions regarding your status.

You have the right to review your membership files maintained by the System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Practices Act Coordinator, CalPERS P.O. Box 942714, Sacramento, CA 94229-2714

INSTRUCTIONS FOR THE COMPLETION OF FORM HBD-85 (08/2011)

Part A: 1. Type of Action. Check " NEW " if this is a new enrollment.
Check "CHANGE" if family member is added, deleted, or any plan changes.
2. Check applicable Original Qualifying Event and Dates.
3. Provide original event date (separation, date of divorce, etc.).
4. Original COBRA enrollment period.
Examples:
Separation from enrollment 4-15-2010 (Perm. Event) FROM 6-1-2010 TO 11-30-2011
Child attains age 26 on 6-15-2010 (Perm. Event) FROM 7-1-2010 TO 6-30-2013

Part B: 5. Please provide all requested information.
6. If the COBRA enrollee is a former dependent, the employee/retiree must be identified in Box 6.

Part C: 7. Please identify the carrier. The COBRA enrollee must continue the same coverage which he or she had as an employee or as a dependent. Carrier changes are only allowed during the open enrollment period or if the enrollee moves into or out of a carrier's geographic service area. The carrier's name, address, phone number, plan code, and premium can be found in the annual "Health Plan Decision Guide" which is available in all employing agencies. The monthly premium may not exceed 102% of the group rate.

Part D: 8. List all family members to be enrolled, including self.
Action Code: Use "A" to indicate which person is being added (or newly enrolled).
Use "D" to indicate if an individual is being deleted from an existing COBRA enrollment.
An Action Code is not required when changing carriers.
IMPORTANT: The addition or deletion of family members is regulated by time limits which are identical to those for active enrollees (subscribers).

Part E: 9-10 Name and Plan Code of prior health plan if COBRA coverage is being changed.

10-13 To be completed by the Health Benefits Officer.

Part F: 14. Signature of COBRA enrollee and date signed.

Part G: 15-16. To be completed by the (former) employing agency. For (former) dependents of retirees, CalPERS is the "employing agency".

IMPORTANT: It is the responsibility of the COBRA enrollee to report enrollment changes in a timely manner. Enrollment change requests must be submitted in accordance with existing regulations, laws, and the time limits applicable to the Public Employees' Medical and Hospital Care Act. All change requests are directed through the agency listed in Part G.